



Department of Defense INSTRUCTION

MASTER COPY DO NOT REMOVE FROM FILE

March 13, 1985
NUMBER 1010.6

ASD(HA)

SUBJECT : Rehabilitation and Referral Services for Alcohol and Drug Abusers

- References:
- (a) DoD Instruction 1010.6, "Rehabilitation and Referral Services for Alcohol and Drug Abusers," August 12, 1981 (hereby canceled)
 - (b) DoD Directive 1010.4, "Alcohol and Drug Abuse by DoD Personnel," August 25, 1980
 - (c) Assistant Secretary of Defense Multiaddressee Memorandum, Department of Defense Policy Concerning Treatment of Persons Identified as Drug Dependent, June 23, 1982 (hereby canceled)
 - (d) DoD 4515.13-R Chapter 11-4.d.(1), "Air Transportation Eligibility," January 1980
 - (e) Public Law 98-24, "Public Health Services Act" of Apr 26, 1983 (97 Stat. 182)
 - (f) through (j) see enclosure 1

A. REISSUANCE AND PURPOSE

This Instruction reissues reference (a), cancels reference (c), and updates policy, procedures, and responsibilities in regard to the DoD rehabilitation and referral services in execution of reference (a).

B. APPLICABILITY AND SCOPE

1. This Instruction applies to the Office of the Secretary of Defense, the Military Departments, the Organization of the Joint Chiefs of Staff, the Unified and Specified Commands, and the Defense Agencies (herein referred to collectively as "DoD Components").

2. It issues alcohol and drug abuse rehabilitation and referral guidance for DoD military and civilian personnel.

3. It describes the relationship between the Department of Defense and the Veterans Administration with regard to drug and alcohol abuse treatment.

C. DEFINITIONS

Terms used in this Instruction are defined in enclosure 2.

D. POLICY

1. In order to retain the maximum number of qualified personnel, the Department of Defense shall identify personnel at risk for drug or alcohol

abuse and alcoholism, and counsel or rehabilitate active duty members, guard and reserve personnel by providing residential, nonresidential, consultive and educational services to ensure the military's peacetime and combat readiness missions are met. Those military members who are identified as drug or alcohol dependent by qualified medical personnel (licensed physicians or psychologists) shall be detoxified when appropriate, referred or rehabilitated. Rehabilitative and educational services shall be provided, when feasible, to the family members of DoD personnel and other eligible beneficiaries.

2. Information, assistance, and referral services shall be made available to all eligible DoD civilian employees. Referral to the appropriate level of treatment or counseling shall meet the intent of this Instruction. Active duty members or DoD civilian personnel diagnosed as having alcohol or other drug abuse problems who refuse to accept referral for treatment, or who persistently fail to attend appropriate follow up or aftercare services and continue to abuse alcohol or other drugs shall be considered for termination of duties or employment.

3. With the exception of licensed medical personnel, DoD components shall establish standardized criteria for the selection and certification of personnel who serve in clinical roles as alcohol and drug abuse counselors.

a. The requirement for certification of DoD alcohol and drug abuse counselors shall include sufficient knowledge and skills relating to the core tasks required of rehabilitative personnel followed by a structured didactical course pertaining to substance abuse. A supervised one year internship shall be the minimum prerequisite for the final evaluation and assessment of a counselor's competency for certification.

b. Personnel, such as Employee Assistance Personnel (EAP) representatives who do not have the clinical responsibility of treatment or aftercare are not required to have certification. Civilian or military personnel who do have clinical responsibilities of treatment, consultation or aftercare shall receive certification by their Service, a state, or the Federal Government. Substance abuse counselors who do not meet standards developed by their Service shall obtain the training and supervision necessary to meet these standards within two years following the publication of this Instruction.

c. Licensed health care providers (physicians, psychologists, clinical social workers, and psychiatric nurses) working in direct care, managerial, or supervisory roles over drug and alcohol abuse personnel shall have additional training in chemical dependency.

4. Rehabilitation and referral services for alcohol and drug abusers shall be coordinated with other military programs serving populations at high risk for substance abuse, such as programs for child and spouse abuse, exceptional family members programs, hospitals medical and surgical services.

E. PROCEDURES

1. Before the initiation of rehabilitation for substance abuse by a DoD program, all personnel shall be medically evaluated for physiological dependence. Subsequently, if found to be physically dependent the patient shall be detoxified by medical personnel. DoD personnel referred for rehabilitation to non DoD programs shall be informed of the importance of obtaining a medical evaluation for detoxification.

2. Military Residential Rehabilitation

a. Staff

(1) The Military Services shall develop criteria that determine the minimum number of appropriately trained professionals, rehabilitation personnel, and support staff required to ensure program effectiveness. Organizational plans shall be available defining the delegation of authority within the program.

(2) Staff members shall be under the direct supervision of personnel qualified to evaluate their performance.

(3) Staff members shall be afforded the opportunity to continue their professional growth and development.

(4) Job descriptions and responsibilities shall be available for staff and other organizational reviews.

b. Program

(1) Therapeutic Concept. The program's philosophy of residential rehabilitation shall reflect a multidisciplinary approach using appropriate self-help groups and advances in the treatment of chemical dependency. Rehabilitation for polyaddicted patients shall be evaluated on a case by case basis. An individual rehabilitation plan shall be developed for each patient, and treatment progress shall be evaluated against the goals specified in this plan.

(2) Program Entry and Termination Criteria

Criteria shall be established to determine the eligibility of patients for entry into residential rehabilitation.

(a) Intake procedures shall involve a command consultation, a medical evaluation to assess the need for detoxification, a psychological evaluation, and a social history to determine the patient's requirements for rehabilitation.

(b) Criteria for completion of residential services shall be established and incorporated in the initial rehabilitation plan. Reasons for early termination of treatment shall be addressed to the patient and documented in his or her treatment record before making a decision to discharge the patient from the rehabilitation program. No one shall be given an early

discharge from rehabilitation without appropriate documentation in his or her medical record. A diagnosis and prognosis shall be given to each patient with a copy going to the military member's commanding officer.

(c) The commanding officer in conjunction with the rehabilitation staff shall be involved in the individual rehabilitation program. Written consent shall be required from non-military DoD members who are treated in DoD facilities to allow for supervisor participation.

(d) Military members considered for residential rehabilitation shall have demonstrated a genuine potential and desire for further useful service as well as a high probability for successful rehabilitation. Patients meeting one or more of the following criteria shall ordinarily be treated in a residential program.

1 Patients with a Diagnostic and Statistical Manual - III (DSM-III) criteria of Alcohol Dependence (303.91), or the International Classification of Diseases-9 (ICD-9) diagnosis of Alcohol Dependence Syndrome (303), or equivalent.

2 Patients with repeated alcohol related events of a maladaptive nature.

3 Patients with a chronic history or pathological use of alcohol and/or other drugs who demonstrates withdrawal and/or evidence of tolerance.

(3) Program Components. Each program component shall have a Standard Operating Procedure (SOP) manual designed to meet fundamental patient needs.

(4) Family Involvement. Initial patient assessment shall include family data. An initial plan for family involvement in rehabilitation shall be included whether or not the family member or other significant person attends. Emphasis on this portion of the program shall be made known to the patient before entry and again at time of entry to a program. Lack of participation by family members shall not preclude treatment for the drug or alcohol abuser.

(a) When existent, the family member or co-dependent's illness shall be viewed as a separate condition.

(b) Within the limitations of existing regulations, the family member shall have a high priority in receiving rehabilitation when identified as a co-dependent.

(c) Within the limitations of existing regulations, the family member or co-dependent spouse shall receive administrative support and assistance when being air transported for treatment, implementing DoD 4515.13-R (reference (d)).

(d) Within the limitations of available resources, the local command or hospital shall arrange for appropriate accommodations for the family member or co-dependent spouse.

(e) When necessary, the family member or co-dependent spouse should be assisted in making arrangements with his or her employer to attend treatment.

(5) Aftercare. Programs shall include an individualized plan designed to identify the continued support of the patient with monthly monitoring (minimally) during the first year after the date of entry into the program. Changes in responsibility or duty station do not eliminate the requirement for continued follow-up, and require communication between losing and gaining treatment staff.

(a) Slips and recidivism are typical manifestations of the recovering substance abuser. A slip may facilitate the recovery process when the patient presents the slip to his or her counselor or group for evaluation.

(b) Every effort shall be made to involve the patient's commander and supervisor in the implementation of the aftercare plan. For personnel not subject to the Uniform Code of Military Justice (UCMJ), written consent from the patient must be obtained in order to allow for a supervisor's participation under Public Law 98-24, Apr. 26, 1983 (97-Stat. 182) (reference (e)) and 42 U.S.C. , Sec 29 old-3 (reference (f)).

(c) Commanders and supervisors shall be informed in writing that residential or inpatient admission is only the initial stage of treatment, to be followed by an intensive aftercare rehabilitation program. The written individualized plan shall be provided to the military member's commander. During the patient's first year of recovery, a quarterly evaluation of the patient's progress shall be conducted by a committee comprised of the patient's commanding officer, his or her representative, the patient, and an aftercare coordinator or the patient's substance abuse counselor.

(d) Commanders and supervisors shall be made aware of the inducements in the work and family environment that contribute to continued drinking or drug abuse.

c. Quality Assurance

(1) Rehabilitation and referral services shall meet current quality assurance standards and have as an objective compliance with the Joint Commission on Accreditation of Hospitals (JCAH) for alcohol and drug abuse facilities.

(2) Outcome criteria shall be established for each patient against which progress may be measured.

(3) Case evaluations and reviews shall be in compliance with the confidentiality requirements for drug and alcohol treatment under Public Law 98-24, Apr. 26, 1984 (97 Stat. 182) (reference (e)) and 42 U.S.C., Sec. (reference (f)) respectively.

3. Military Nonresidential Rehabilitation

a. Staff

(1) DoD Components shall develop criteria that determine the minimum number of appropriately trained professionals, rehabilitation personnel, and support staff required to ensure program effectiveness. Organizational plans shall be available defining the delegation of authority within the program.

(2) Staff members shall be under the direct supervision of personnel qualified to evaluate their performance.

(3) Staff members shall be afforded the opportunity to continue their professional growth and development.

(4) Job descriptions and responsibilities shall be available for staff and other organizational-reviews.

b. Program

(1) Therapeutic Concept. The program's philosophy of non-residential rehabilitation shall reflect a multidisciplinary approach. Military Service nonresidential programs shall be standardized (intra Service) to reflect program continuity using, when appropriate, self-help groups and incorporating advances made within the speciality of substance abuse treatment.

(2) Program Entry and Termination Criteria. Criteria shall be established to determine the eligibility of patients for entry into non-residential rehabilitation.

(a) Intake procedures shall involve a command consultation, a medical evaluation to assess the need for detoxification, a psychological evaluation, and a social history to determine the patient's requirements for rehabilitation.

(b) Criteria for completion of nonresidential services shall be established and incorporated in the initial rehabilitation plan. Reasons for early termination of treatment shall be addressed to the patient and documented in his or her treatment record prior to a decision to discharge the patient from the rehabilitation program. No one shall be given an early discharge from rehabilitation without appropriate documentation in his or her medical record. A diagnosis and prognosis shall be given to each patient with a copy to the military member's commanding officer.

(c) The commanding officer, in conjunction with the rehabilitation staff, shall be involved in the individual's rehabilitation program. Written consent shall be required from non-military DoD members to allow for supervisor participation.

(d) Nonresidential rehabilitation criteria for intensive outpatient treatment may include the criteria described above under residential

rehabilitation for program entry (E.2.b. (2)(a) 1 and 2). Patients meeting one or more of the following criteria shall ordinarily be treated in a non-residential program.

1 Patients with a Diagnostic and Statistical Manual-III (DSM-III) criteria of Alcohol Abuse (305.0) or the International Classification of Diseases-9 (ICD-9), diagnosis of Alcohol Abuse (305.0) or equivalent.

2 Patients whose use of alcohol and/or other drugs that resulted in self-destructive or other destructive consequences on one or more occasions.

3 Patients who manifest early patterns of misuse of alcohol and despite serious consequences emotionally, socially, or physically, continue to drink or use illicit drugs.

4 Patients in need of intervention, due to pathological use of alcohol or use of illicit drugs, who are emotionally and physically stable and have not received prior treatment.

5 Patients who have received residential treatment who have relapsed and need further treatment.

(3) Program Components. Each program component shall have a Standard Operating Procedure (SOP) manual designed to meet fundamental patient needs.

(4) Family Involvement. Initial clinical assessment of the identified patient shall include family data. Every effort shall be made for family involvement.

(a) Family members shall be afforded an opportunity for counseling or rehabilitation, as appropriate.

(b) The alcoholic patient shall be educated to the necessity for family involvement at the outset of treatment.

(5) Aftercare. The aftercare program shall assist the individual in developing a continuing support plan that will involve the patient's commander. The patient shall have a written plan describing the military member's further rehabilitative responsibilities with a copy to his or her commander. Slips and recidivism are typical manifestations of recovering substance abusers. The patient's progress shall be evaluated on a quarterly basis during his or her first year of recovery by a committee comprised of the patient, an alcohol counselor or aftercare coordinator, and the patient's commanding officer or representative.

c. Quality Assurance

(1) Rehabilitation and referral services shall meet current quality assurance standards and have as an objective compliance with the Joint Commission on Accreditation of Hospitals (JCAH) for alcohol and drug abuse facilities.

(2) Outcome criteria shall be established for each patient against which progress may be measured.

(3) Case evaluations and reviews shall be in compliance with the confidentiality requirements for drug and alcohol treatment under Public Law 98-24, Apr. 26, 1983 (97-Stat. 182) (reference (e)) and 42 U.S.C., Sec. 29 Odd-3 (reference (f)) respectively.

4. DoD Alcohol Awareness Programs.

a. Those who have lost their installation driving privileges as a result of intoxicated driving, or received an official report, or refused to submit to a lawfully requested blood-alcohol content test are mandated to complete an alcohol or drug safety action program in accordance with DoD Instruction 1010.5 (reference (g)) and DoD Directive 1010.7 (reference (h)).

b. Those who are directed to complete an alcohol and drug awareness program and judged not to meet entry criteria for residential or nonresidential programs shall have an evaluation to assess whether or not further treatment is indicated.

c. A report shall be sent to the individual's commander or, for civilian personnel, supervisor following the completion of the program or upon disenrollment. For those not coming under the UCMJ a consent form must be obtained before reporting back to their supervisor.

5. DoD Referral Services

a. Staff

(1) Components shall have programs and staff trained in problem assessment and referral. If referral personnel give diagnoses, conduct counseling or therapy groups, or otherwise enter into treatment with alcohol or drug abuse patients, they shall have appropriate certification as described under "Policy" D.3.a. & b., in this Instruction.

(2) Technical supervision and assistance shall be made available to the staff.

(3) Staff members, to include civilian additional duty personnel, shall be afforded the opportunity to continue their professional growth and development.

(4) Job descriptions and responsibilities shall be available for staff and other organizational reviews.

b. Program

(1) Guidelines

(a) Component programs shall offer referral services on a routine basis.

(b) Procedures shall be established that specify the mechanism by which, and the conditions under which, referrals are made.

(c) There shall be documentation of the number of individuals screened and the type of referrals made.

(2) Patient Assessment. Patient assessment shall determine the need for further assessment or rehabilitation services. Individualized treatment plans that consider the nature or severity of alcohol or drug abuse shall make recommendations on a case by case basis. Programs shall be tailored to patient needs whether residential, nonresidential, or educational.

(3) Referral Resources. Referral service personnel shall keep a complete list of available rehabilitation and community support services. Programs of interest to the patient shall be described to include eligibility requirements, cost, and type of treatment. Liaison between the referring agency and program chosen by the patient shall be maintained.

(4) Followup. A plan shall be established to obtain a followup report 'from the receiving agency within' a "designated period of time that assures appropriate followup rehabilitation for the referred patient. The patient's progress shall be evaluated on a quarterly basis during the first year of recovery by a committee comprised of the patient, a substance abuse counselor or aftercare coordinator, and the patient's commanding officer or representative. Followup actions and reviews shall be in compliance with the requirements of confidentiality under Public Law 98-24, Apr. 26, 1983 (97-Stat. 182) (reference (e)) and 42 U.S.C., Sec. 29 old-3 (reference (f)).

c. Quality Assurance. Periodic reviews shall be conducted to evaluate the quality and completeness of intake activities, the appropriateness of the referral, followup actions and, to the extent possible, the quality of care provided by the referral resource.

6. Intervention

a. A structured intervention is an effective means of introducing a potential patient to the need for evaluation and treatment for alcoholism or other drug abuse. This process should be employed whenever possible before an individual enters a treatment program in an effort to increase the efficacy of treatment.

b. Optimally, this event should include family, peers and supervisors who have been prepared in advance of the intervention by meetings with professional staff from their Military Service or EAP rehabilitation personnel.

7. Veterans Administration. The Department of Defense and the Veterans Administration working in concert should share resources under P.L. 96-22 (reference (i) and (j)) when beneficial and feasible.

a. Residential VA Rehabilitation. When mutually agreeable, and authorized by law, DoD Components may choose to use VA residential programs for DoD members using the criteria described under E.2.b. (2).

b. Nonresidential VA Rehabilitation. Nonresidential VA rehabilitation when appropriate and mutually advantageous should be used when feasible. Criteria for entry are described at E.3.b. (2).

c. Rehabilitation for DoD Members to be Discharged. Personnel who are to be discharged for drug and alcohol abuse may be referred for rehabilitation to a VA facility when mutually agreed upon by the referring agency and the VA facility. Within the legal requirements of patient confidentiality and release of information, the VA facility shall be provided appropriate records, such as a copy of the member's Military Service record, and the nature of the member's discharge. The member shall be informed of this opportunity for rehabilitation. Alcohol or drug dependent Service members who are evaluated as not having potential for further useful-service, if discharged, are to be evaluated by a physician, provided with appropriate care to include detoxification if needed, and referred to a VA facility for further rehabilitation in accordance with the provisions of P.L. 96-22 (reference (i)) and P.L. 97-174 (reference (j)) or to some other local civilian rehabilitation facility near the service member's home of record or place of residence after separation.

8. DoD Joint-Service and VA Oversight Committee .

a. A DoD Joint-Service Oversight Committee is hereby established to coordinate policy and resources among DoD Components, and among DoD Components and the Veterans Administration.

b. This Committee shall be chaired by a representative from the Office of the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) with representation from the Army, Navy, Air Force, Marines, and by invitation; the Veterans Administration who are knowledgeable and trained in the area of substance abuse treatment.

c. This Committee shall make recommendations to the Deputy Assistant Secretary of Defense (Professional Affairs & Quality Assurance) (DASD(PA&QA)) regarding treatment and rehabilitation matters of joint Service and VA interest.

9. Program Evaluation

An evaluation program shall be established by each DoD Component to measure the extent to which services provided meet organizational needs and program goals.

F. RESPONSIBILITIES

Heads of DoD Components shall implement the policies and provisions of this Instruction.

Mar 13, 85
1010.6

G. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately for purpose of preparing implementing documents. Implementation shall commence by August 1, 1985. Forward two copies of implementing documents to the ASD(HA) by July 1, 1985.

William Mayer, M.D.

William Mayer, M.D.
Assistant Secretary of Defense
(Health Affairs)

Enclosure - 2

1. References
2. Definitions

DEFINITIONS

1. Intervention. The process of getting the potential patient's attention for the need of rehabilitation at the earliest possible moment due to self-destructive drinking or drug abuse. This professionally structured event should be a commander (military personnel) and/or supervisor (civilian personnel) responsibility coordinated by the trained professional staff. This method of interrupting substance abuse and dependence can be used at any time but may be especially useful with senior level patients. Consultation by professional staff from the member's Military Service rehabilitation program or an Employee Assistance Program is expected before an intervention is conducted.

2. Detoxification. Planned management of the alcohol and drug withdrawal processes. Medical detoxification generally is accomplished on an inpatient basis, and includes withdrawing alcohol and other drugs of abuse from the individual, and providing indicated medical and psychological support.

3. Rehabilitation. The process of restoring to effective functioning persons impaired by the use of alcohol or other drugs.

4. Residential Rehabilitation. Rehabilitative services provided on a 24-hour, live-in basis for those who have been diagnosed as dependent on alcohol or drugs.

5. Nonresidential Rehabilitation. Rehabilitative services provided on a nonlive-in basis for those who abuse alcohol or other drugs.

6. Referral Services. Information and assistance provided to those who abuse alcohol and drugs for locating appropriate rehabilitative education, ancillary services, or community support groups.

7. Rehabilitation Personnel. Trained members of the alcohol and drug abuse program staff qualified to provide consultative, rehabilitative, or referral services.

8. Support Staff. Members of an alcohol or drug abuse rehabilitation or referral program whose primary work activities involve clerical, housekeeping, security, laboratory, **recordkeeping**, or other nonmanagerial functions necessary for the overall clinical and administrative operation of the program.

9. Co-Dependent. A family member or other significant person who is emotionally related to the alcohol or drug abuser who, in the setting of this relationship, has developed a psychological, social, or physical **illness**. When the **family member or other significant person** becomes emotionally distressed or physically ill as a result of the relationship to a substance abuser, the term co-dependent appropriately applies.

10. Drug. Any substance, other than food, that is inhaled, injected consumed, or introduced into the body in any manner, to alter **mood or function** is considered a drug in this Instruction.

11. Substance Abuse. The generic term for the use of any illicit drug or the misuse of any prescribed medication or the abuse of alcohol. Abuse refers to **any** pattern of unconventional misuse of any substance for **nonmedical**

purposes that produced a known health risk, or danger, to self, or others. Diagnosis of abuse shall require evaluation by a licensed physician, psychologist or social worker trained in substance abuse or by a certified substance abuse counselor under the direct supervision of the aforementioned medical personnel.

12. Level of Treatment or Rehabilitation. The term level in this Instruction refers to an educational (first), nonresidential (second), or residential (third) approach to creating positive change or rehabilitation in DoD personnel.

13. Slip. A temporary resumption of substance abuse that is brought to the attention of the health care provider and immediately terminated by the substance abuser.